SPECIAL TERMS AND CONDITIONS
(Extension July 1, 2000 - June 30, 2005)

NUMBER: **11-W-00076/9**

TITLE: The State of California's Section 1115 Medicaid Demonstration Project for Los Angeles County

AWARDEE: State of California as the Single State Agency

TABLE OF CONTENTS

Page

I. PREFACE 2

II. GENERAL CONDITIONS 3

III. LEGISLATION 5

IV. RESTRUCTURING 6

V. PROGRAM DESIGN/OPERATIONAL PLAN 16

A. Population Included in the Extension of the Project 16
B. Delivery System 17
C. Access 18
D. Quality Assurance/Quality Improvement 18
E. Monitoring 19
F. Management Information Systems 19

ATTACHMENTS

Attachment A Requirements for Federal Financial Participation/Cost Control/Fiscal Administration
Attachment B General Administrative Requirements
Attachment C General Reporting Requirements
Attachment D Monitoring Budget Limits

I. PREFACE

On April 15, 1996, the Health Care Financing Administration (HCFA) issued Special Terms and Conditions governing the State of California's Section 1115 Medicaid Demonstration Project for Los Angeles County ("Project"). The Project was approved for a term of five years (July 1, 1995 through June 30, 2000.) Thereafter, further discussion among HCFA, State and County representatives led to changes to the Project. Special Terms and Conditions (Amendment No. 1) approved on June 14, 1996 and Special Terms and Conditions (Amendment No. 2) approved on June 30, 1997 incorporated additional changes agreed to among the parties. The Special Terms and Conditions were subsequently amended as reflected in correspondence among the parties dated December 29, 1998, from the State to HCFA and April 21, 1999, from HCFA to the State. This correspondence concerned the impact to the Project budget neutrality limit for Project Years (State fiscal years) 1997/98 and 1998/99 resulting from the increase to 175 percent of uncompensated costs for the OBRA 1993 disproportionate share hospital (DSH) payment limit as amended by the Balanced Budget Act of 1997.

HCFA granted an extension and phase-out of the Project over a term of five years (July 1, 2000 through June 30, 2005), hereafter referred to as the "extension period," to continue to assist the County in restructuring its health care delivery system to ensure its long-term viability and reduce the County's reliance on Federal demonstration revenue. These approved Special Terms and Conditions govern this extension.

Unless otherwise specified, the definition of terms used in this document are the same as set forth in the "Medicaid Demonstration Project for Los Angeles County" submitted by the State on February 29, 1996 ("State/County Proposal").

The Special Terms and Conditions have been arranged into four broad subject areas: General Conditions; Legislation; Restructuring; and Program Design/Operational Plan. Specific requirements are attached, entitled: Requirements for Federal Financial Participation/Cost Control/Fiscal Administration (Attachment A); General Administrative Requirements (Attachment B); General Reporting Requirements (Attachment C); and Monitoring Budget Limits (Attachment D).

II. GENERAL CONDITIONS

A. Federal financial participation (FFP) will be available for project development and implementation and for compliance with these Special Terms and Conditions.

B. All Special Terms and Conditions prefaced with an asterisk (*) contain requirements that must be approved by HCFA. Unless otherwise specified, where the State is required to obtain HCFA approval of a submission, HCFA will make every reasonable effort to respond to the submission in writing within 30 days of receipt of the submission. HCFA and the State will make every reasonable effort to ensure that a decision has been rendered on each submission within 60 days from the date of HCFA's receipt of the original submission.

C. HCFA approved on January 12, 1997, the protocol document ("Operational Protocol") that provides a single source for the policy and operating procedures applicable to the Project which have been agreed to by the State, County and HCFA. Subsequent amendments to the Operational Protocol have been adopted by the State and County and approved by HCFA. The Operational Protocol shall be amended as necessary to reflect these Special Terms and Conditions in accordance with Attachment B.

D. The State and County entered into an Interagency Agreement that identifies elements of the Special Terms and Conditions that will be undertaken by the County. The Interagency Agreement was approved by HCFA on December 11, 1996, and incorporated into the Operational Protocol for the Project. Subsequent amendments to the Interagency Agreement have been adopted by the State and County and approved by HCFA. The Interagency Agreement shall be amended as necessary to reflect these Special Terms and Conditions in accordance with Attachment B.

E. HCFA may suspend or terminate any project in whole or in part at any time before the date of expiration, whenever HCFA determines that the State has materially failed to comply with the terms of the project. HCFA will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights to challenge any HCFA finding that the State or County has materially failed to comply. HCFA reserves the right to withdraw waivers at any time if it determines that continuing the waivers would no longer be in the public interest. If a waiver is withdrawn, HCFA will only be liable for normal close-out costs.

F. The State will comply with the requirements of all of the Attachments to the Special Terms and Conditions including:

1. Requirements for Federal Financial Participation/Cost Control/Fiscal Administration (Attachment A)
2. General Administrative Requirements (Attachment B)
3. General Reporting Requirements (Attachment C)
4. Monitoring Budget Limits (Attachment D)

III. LEGISLATION

A. All existing requirements of the Medicaid program expressed in law not expressly waived or identified as not applicable in the award letter of which these Special Terms and Conditions are a part shall apply to the extension of the Project. To the extent that the enforcement of such laws through regulations and official policy statements issued by a Center Director and/or Associate Regional Administrator or higher HCFA official after the date of approval of the extension of the Project would have an effect on the availability of FFP for the expenditures described in paragraph 1 of Attachment A, HCFA will conduct an assessment of such funding mechanisms and negotiate revisions with the State to comply with the law, regulations or policy statement. All revisions must comply with the annual and total budget limits as described in Attachment D.

B. Approval of the extension of the Project is not intended to excuse the State's compliance with any changes in Federal law or regulation affecting the Medicaid program that occur after the date of approval of the extension of the Project. To the extent that a change in Federal law or regulation, which does not exempt section 1115 demonstration projects or this extension of the Project specifically, would affect the availability of FFP for the expenditures described in paragraph 1 of Attachment A, HCFA will conduct an assessment of such funding mechanisms and negotiate revisions with the State to comply with the law or regulation. All revisions must comply with the annual and total budget limits as described in Attachment D.

C. The State may submit to HCFA an amendment to the extension of the Project to request exemption from, or to modify the extension of the Project to conform with, changes in law, regulation or policy occurring after the date of approval of the extension of the Project. The cost to the Federal government of the implementation of any such amendment must not increase FFP above the annual and total budget limits described in Attachment D.

IV. RESTRUCTURING

A. Phase I (July 1, 1995 - June 30, 1996)

As part of Phase I, the State was tasked to:

1. Stabilize the County health care system through service restoration and re-configuration.

2. Identify revenue sources (private, philanthropic, or State) to ensure viability of the County health care system during Phase II and after the Project ends.

B. Phase II (July 1, 1996 - June 30, 2000)

1. The State established an Oversight Committee comprised of State and County senior officials, with a formal mechanism for public input, that was responsible for directing the Project, monitoring progress, and ensuring achievement of goals. This mechanism for public input ensured that health care providers, content experts, employee organizations, and recipients of care (or their representatives) had the opportunity to present their views on issues under consideration by the Oversight Committee. HCFA senior officials provided technical assistance to the Oversight Committee and made every effort to attend key meetings.

2. The State submitted, and HCFA approved on April 1, 1998, a detailed "Project Management Plan" for restructuring the County health care system that provided specific, measurable goals, milestones, time-lines, cost estimates, and responsible parties for the achievement of the goals. The Project Management Plan addressed: the segmented and complex maze of public and private service providers and sites; lack of uniform patient identification; duplicate eligibility and intake procedures; service networks and referral pathways in need of improvement; inappropriate use of emergency rooms and urgent care services for otherwise routine health care needs; and potentially preventable hospitalizations for individuals with chronic medical conditions.

3. During the second year of the Project, HCFA, the State and the County undertook a cooperative effort to plan the restructuring of the County's health care system, which led to the development of the Project Management Plan. In addition to the cost estimates, the following milestones were reflected in the approved Project Management Plan:

a. Expansion of outpatient services provided in County Comprehensive Health Centers (CHCs), Health Centers and clinics.

b. Preservation of trauma and emergency care systems for appropriate use.

c. Implementation of system transformation measures, including:

- consolidation of various programs and funding streams to establish a single level of eligibility for all medically indigent persons;

- development of a comprehensive service package in each geographic area, including specialty care at CHCs where feasible and appropriate;

- restructuring the traditional, teaching-hospital approach to patient care toward a managed care/medical group practice model that emphasizes high quality, efficient primary care, and problem oriented, time-limited secondary care in conjunction with strong, university-linked hospitals providing tertiary care; and

- development of specific clinical guidelines for appropriate referrals to specialty clinics, etc.

d. Improvement of the County's specialty referral system, including creation of additional, timely, specialty appointment slots for new referrals.

e. Identification and implementation, as appropriate, of efficiencies/consolidations and reengineering to assure a cost-effective system.

f. Transition of the County health care system to a more cost effective managed care system beginning with a strong participation in the Two-Plan Model for Medi-Cal managed care.

g. Development of a human resource plan to include staff development and retraining programs to support the reconfigured health care delivery system.

C. Extension of Project (July 1, 2000 - June 30, 2005)

1. Phase-Out of Federal Demonstration Funding

   Federal demonstration funding will be phased out over the approved five-year extension period (July 1, 2000 through June 30, 2005) in compliance with the annual and total budget limits as detailed in Attachment D.

2. Project Oversight

   The Oversight Committee established during Phase II of the Project will continue to operate during the extension period. This mechanism for public input will continue to ensure that health care providers, content experts, employee organizations, and recipients of care (or their representatives) have the opportunity to present their views on issues under consideration by the Oversight Committee. HCFA senior officials will continue to provide technical assistance to the Oversight Committee and will make every effort to attend key meetings.

3. Project Management Plan

   Except as otherwise provided in these Special Terms and Conditions, the Project Management Plan developed under Phase II of the Project shall not govern the restructuring of the County's health care system during the extension period and shall be superceded by the Monitoring Plan required pursuant to Section IV.C.6.a.

4. Additional County Financial Commitments

   As part of this extension agreement, the County commits to invest $300 million of the tobacco litigation settlement funds and an additional $100 million of General Fund contributions for demonstration-related services during the extension period. In addition, the County Department of Health Services (DHS) will institute an austerity program, consisting of non-service cost reductions, such as purchasing and consulting fees that will result in an additional $91 million in savings to the County DHS over the five-year extension period.

5. * Worker Retraining

   a. By February 1, 2001, the County will develop and the State will submit a work plan for HCFA and the Federal Department of Labor (DOL) review to address workforce training and restructuring activities in the County's health care system. HCFA and Federal DOL will provide comments on the work plan within forty-five (45) days from the date of submission of the work plan.

   b. As part of this extension agreement, a minimum of $40 million in State and County funds at a 2 to 1 ratio, respectively, will be made

available over the course of the extension period to fund the system's workforce training needs, as identified in the HCFA/DOL approved work plan. Such funds may include non-Medicaid Federal funds made available to the State and County for workforce training purposes, and shall not be subject to the budget limits set forth in Attachment D. FFP will not be available for worker retraining.

6. * Extension Monitoring Plan and Sanctions

a. By February 10, 2001, the State shall submit for HCFA approval a detailed Monitoring Plan for the requirements specified in subsection b of this section. This plan shall include specific requirements, milestones, time-lines, cost estimates, responsible parties, and a mechanism for monitoring progress towards milestones and these requirements. This Monitoring Plan shall be incorporated into the Operational Protocol.

b. The requirements in the Monitoring Plan shall include, at a minimum:

- Providing a minimum of 3 million outpatient visits annually during the course of the extension, with at least 2.3 million of these visits provided by County clinics and at least 700,000 visits provided by Public/Private Partnerships (PPPs). The County has the option of meeting the overall 3 million outpatient visit requirement with fewer than 2.3 million County clinic visits, if PPP visits over 700,000 meet or exceed the County clinic shortfall and the County provides an advance written report to the State with the following elements:

  - The results of a community consultation process that includes PPP participation;
  - An assessment of unmet needs and other access issues in the major geographic area(s) affected;
  - A capacity analysis of relevant providers available to increase their PPP visits in the major geographic areas affected;
  - Implementation of the provisions necessary to assure continuity of care to affected patients, including adequate notice of changes in service;
  - A method to assure that affected patients have continued access to necessary specialty and inpatient services; and
  - A capacity review of PPPs demonstrating access to a full scope of primary care services, clinical competence, cultural competence, and language appropriateness.

  County clinics include CHCs, Health Centers (excluding clinics that provide predominately public health services), public mental

health clinics operated by County Department of Mental Health (DMH), and hospital-based clinics. PPP sites include private clinics that provide health services to the indigent (including General Relief recipients) under contract with County DHS, and private mental health clinics under contract with County DMH.

- Implementing Clinical Resource Management (CRM) practices that result in savings of $3 million in State fiscal year (SFY) 2003-04 and $6 million in SFY 2004-05 to the County DHS.

- Submitting applications to the Health Resources and Services Administration (HRSA), when appropriate, to achieve Federally Qualified Health Center (FQHC) or FQHC look-alike status for County and PPP clinics, not already having FQHC or FQHC look-alike status. Due dates for application submittal shall be outlined in the Monitoring Plan.

- Guaranteeing through State and Federal payments that all FQHCs and FQHC look-alike clinics (as defined in Section 1905(l)(2)(B) of the Social Security Act) participating in the extension of the demonstration are reimbursed at 100 percent of reasonable costs for Medicaid services rendered to Medicaid beneficiaries throughout the five-year extension period. Private FQHCs or FQHC look-alike clinics are considered to be participating in the extension of the demonstration project during the period in which they have a contract with the County as a PPP.

- Simplifying the County's financial screening process to determine an uninsured individual's ability to pay for health care services at County hospital outpatient departments and clinics.

- Developing a process to assure that all children and adults who receive health care services through the Project delivery system under the extension are provided the opportunity to apply for Medi-Cal, Healthy Families, Kaiser Kids, and other health coverage.

- Increasing the total number of certified eligible Medi-Cal persons in Los Angeles County (excluding only CalWORKS and Long Term Care), as specified in the chart below, beginning with a baseline number of 783,729 eligibles as of June 30, 2000. Any overage in total eligible persons in any year does not raise the total number of eligibles for the following year. The total number of certified eligibles will be tracked by the State's monthly MEDS reports.

Month of Eligibility	*Total Certified Eligibles

June 2001	950,000
June 2002	997,500
June 2003	1,047,400
June 2004	1,099,800
June 2005	1,154,800

*Note: the numbers are rounded up to the next hundred.

- Updating County coding systems to conform to all Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements for its Medi-Cal program, concurrent with the State's compliance with HIPAA.

c. If the requirements in the above-described Monitoring Plan are not met, the State may impose sanctions on the County in the form of reducing funds from the County's claim for demonstration funding, as follows: 1) 10 percent from the Supplemental Project Pool; 2) 8 percent from the Supplemental Project Pool and 3) 10 percent from federally reimbursable ambulatory service costs. The State will not claim FFP for any amount of the reduction to the County's claim. Neither the State nor the County will impose any of these sanctions on the County's contracted private providers. Details for imposing these sanctions will be described in the Interagency Agreement and the Monitoring Plan. The Monitoring Plan shall include a detailed description of the mechanism for determining when a sanction should be imposed, the type and magnitude of the sanction to be applied when particular requirements are not met, the process for notifying the County and Federal governments that a sanction will be imposed, the process by which the County may contest the decision to impose a sanction in the event there is a disagreement between the State and the County, and the process for resolving the disagreement. In addition, the Monitoring Plan shall outline which requirements the County will be held accountable for to ensure that the County is not sanctioned for State responsibilities.

7. * State Plan Amendment for Cost-Based Reimbursement

By September 30, 2000, the State must submit to HCFA an amendment to its State Plan, specifying a July 1, 2000 effective date, to reimburse the County's CHCs, Health Centers (excluding clinics that provide predominately public health services), private clinics that provide health services to the indigent (including General Relief recipients) under contract with County DHS, and County DHS hospital-based clinics at 100 percent of reasonable costs for Medicaid services rendered to Medicaid beneficiaries. Provisions of this amendment shall not apply to FQHCs or FQHC look-alike clinics (as defined in Section 1905(l)(2)(B) of the Social Security Act). This amendment must remain in effect until June 30, 2005.

8. * Screening and Enrollment for Health Coverage

By January 31, 2001, the State shall submit a statewide Implementation Plan for ensuring that individuals who are eligible for coverage under the Medi-Cal and Healthy Families programs are enrolled promptly in the appropriate programs. Upon HCFA approval of the Implementation Plan, the State shall submit quarterly status reports by the 15th day of each subsequent reporting period, responding to each of the milestones outlined in the Implementation Plan.

The Implementation Plan shall include the State's plans to comply with all pertinent Federal laws and regulations and to eliminate or reduce barriers to enrollment. At a minimum, the Implementation Plan shall include a detailed description of the State's goals, milestones, and time-lines for each of the areas/issues listed below. These issues fall into the categories of screening of eligibility and timely processing of applications, materials in languages other than English, elimination of the Quarterly Status Report (QSR), redetermination simplification pilot project, issues from the April 7, 2000 State Medicaid Director (SMD) letter, and issues from the draft Medicaid-TANF report following the Regional Office's review of enrollment policies and practices.

Screening of Eligibility and Timely Processing of Applications

a. Applications for medical assistance, including the Medicaid portion of joint applications for Medicaid and other assistance programs, must be processed in accordance with 42 CFR 435.911.

b. California must ensure timely processing of Medi-Cal applications for children screened as potentially eligible based on the joint Medi-Cal/Healthy Families application.

Materials in Languages other than English

c. All forms in use by the public must be translated into the appropriate languages in accordance with California State law and the Office for Civil Rights' Policy Guidance on the Title VI Prohibition Against National Origin Discrimination as it Affects Persons with Limited Proficiency (65 Fed. Reg. 52762 (Aug. 30, 2000)).

Elimination of the QSR

d. The QSR will be eliminated statewide, effective January 1, 2001.

Redetermination Simplification Pilot Project

e. Through a pilot project to commence on July 1, 2001, the County will simplify the redetermination process for Medi-Cal program eligibility. In place of the current annual redetermination process,

the County will send the beneficiary a form to complete and sign to self declare the information needed for redetermination.

The County will conduct the Income Eligibility Verification System (IEVS) match mandated by §1137 of the Social Security Act for all cases being redetermined. However, the County will target the use of the data produced by IEVS in ways that are most cost-effective and beneficial, as outlined in 42 CFR 435.953. By April 1, 2001, a plan listing the categories of information to be excluded from follow-up will be submitted by the State to HCFA for approval per State Medicaid Manual 15804.4. The County will follow up on all discrepancies for categories that have not been approved for exclusion.

The County will contract for an independent evaluation and audit of this pilot project. The results of the evaluation and audit shall be available to HCFA within six months after completion of the first twelve months of the pilot project. The redetermination simplification pilot project will continue during the independent evaluation and audit until it is jointly determined by the State and HCFA to discontinue this pilot project.

Issues from the April 7, 2000 SMD Letter

f. Children eligible under Section 4913 of the Balanced Budget Act of 1997 must be identified, and those children who were inappropriately terminated must be reinstated.

g. All Medicaid eligibility categories must be considered prior to terminating Medicaid. (42 CFR 435.930)

h. Past and current practices must be reviewed to ensure that operational policies and procedures did not result in improper terminations. If such terminations did occur, persons who lost coverage must be reinstated. (42 CFR 435.930)

i. The State must conduct *ex parte* reviews in accordance with the guidelines set forth in the April 7, 2000 SMD letter. (42 CFR 435.902)

j. Medicaid must not be denied or terminated due to inaccurately or inadequately programmed computer systems. (42 CFR 435.930)

k. Individuals may not be required to resubmit or reverify information that is not relevant to ongoing eligibility or subject to change. (42 CFR 435.902 and 435.916)

Issues from the Draft Medicaid-TANF Report

l. The State should develop updated, comprehensive, and consolidated guidance addressing Medicaid eligibility requirements. (42 CFR 435.902 and 431.50)

m. The State must make all public contact workers, for both cash assistance and Medicaid, aware of the eligibility criteria for Transitional Medicaid and counties must make workers aware of the procedures for processing TMA eligibility. (42 CFR 435.903)

n. As the Single State Agency responsible for Medicaid, State DHS should routinely review operations onsite in county offices to ensure that the program is being properly and consistently administered. (42 CFR 431.50 and 435.903)

o. The State must ensure that TANF work orientation requirements and home visits do not present additional delays and barriers to applying for Medicaid.

p. The State must implement procedures to ensure that applicants receive proper assistance in filling out the Medicaid application form, including both the current form and the streamlined form when available.

q. The State shall implement procedures to ensure that eligible individuals who are immigrants or who live in immigrant families are not deterred from applying for or receiving Medicaid. Such procedures shall include, at minimum, providing applicants with simple and understandable information about: (1) eligibility requirements, (2) public charge and the effect of receipt of Medicaid benefits on immigration status, and (3) permissible uses of information that must be disclosed on application forms (42 CFR 435.905). Nothing in this provision shall be construed to require the State to violate the terms of the settlement agreement in Rocio R. v. Belshe and nothing in this provision shall be construed as a waiver of the State's obligations under Title VI of the Civil Rights Act of 1964.

r. Outstationed workers must be placed in FQHCs and FQHC look-alikes in accordance with 42 CFR 435.904 and Social Security Act 1902(a)(55).

s. The State must conduct a study of non-responders (i.e., those whose Medicaid was denied or terminated due to loss of contact or who did not return requested forms) to identify barriers to participation.

t. The State must conduct a study of persons terminated from Section 1931 who did not receive continued coverage under Transitional

Medicaid to determine reasons for non-participation and develop procedures to address them.

V. PROGRAM DESIGN/OPERATIONAL PLAN

A. Population Included in the Extension of the Project

For the period from July 1, 2000 through June 30, 2005, the scope of federally reimbursable ambulatory services costs will be as specified below.

1. The extension of the Project will not expand eligibility for Medi-Cal beyond those individuals otherwise eligible under the State Medi-Cal Plan.

2. Notwithstanding paragraph 1 above, under the extension of the Project, for the period from July 1, 2000 through June 30, 2005, FFP will be available in expenditures for federally reimbursable ambulatory costs (as set forth in Appendix B of the State/County Proposal) incurred by the County in caring for indigent individuals (including General Relief recipients) in CHCs, Health Centers (excluding clinics that provide predominately public health services), private health clinics under contract with County DHS, public mental health clinics operated by County DMH, and private mental health clinics under contract with County DMH. Such costs shall not include the cost of non-emergency care of individuals without satisfactory immigration status or the cost of care for non-indigent individuals, as determined pursuant to these Special Terms and Conditions governing the extension of the Project. Exclusion of these costs is subject to the provisions described below in paragraph 5.

3. The State will comply with Federal Medicaid quality control requirements. The State will ensure that facilities limit the liability of Medi-Cal eligible patients, including copayments and deductibles, to amounts permitted under the State Plan. Payments under the demonstration will not provide a basis for limiting the liability of patients not eligible for Medi-Cal.

4. For purposes of paragraph 2 of this subsection, indigent individuals are those whose income is less than 133 1/3 percent of the Federal poverty level (FPL), and those whose income exceeds that level, but whose liability under an “ability to pay” calculation (or other streamlined demonstration eligibility process approved by HCFA) is found to be less than the cost of services provided. Further, indigent individuals are those who are not eligible for other health care coverage, such as Medi-Cal or Healthy Families.

5. During the initial Project, the County conducted surveys to estimate:

    a. the County offset of non-matchable ambulatory services provided to individuals without satisfactory immigration status; and

    b. the amount of FFP offset for patient liability (i.e., liability of individuals who are either fully responsible for the cost of their services, or partially responsible for the cost of their services

because liability under the “ability to pay” calculation was found to be less than the cost of services).

Based on the results of these surveys, the average percentage was 4.00 % for non-indigent individuals and 13.38% for individuals without satisfactory immigration status. The total percentage of 17.38% shall be applied to all Federally reimbursable ambulatory service cost claims submitted by the State pursuant to Attachment A throughout the extension period. If there is a statutory change with respect to what constitutes satisfactory immigration status, it is agreed upon by all parties that HCFA, the State and County will review this Special Term and Condition.

B. Delivery System

1. For the purpose of reimbursement during the extension period, the delivery system will include: CHCs, Health Centers (excluding clinics that provide predominately public health services), private clinics that provide health services to the indigent (including General Relief recipients) under contract with County DHS, public mental health clinics operated by County DMH, and private mental health clinics under contract with County DMH.

2. * The State will obtain prior approval from HCFA for any significant changes to the model PPP agreements previously approved by HCFA under the Project. FFP will not be available for costs incurred under any such agreement that has been substantially modified until HCFA has approved the modified agreement.

3. The State will notify HCFA of any significant changes to the County health care system, either through service reduction or closures that affect the current availability of facilities and/or services within a reasonable time period prior to initiating such transaction. Further, at the time of notification, the State will provide an explanation of why such action was taken.

C. Access

1. As part of the approved Project Management Plan, the State provided the methodology it uses to determine access. Using this approved methodology, the State shall continue to determine the adequacy of access, including such factors as distance to obtain services, the availability of services for primary, specialty, urgent, and 24 hour emergency care during the extension period. The State shall also continue to monitor facilities to ensure that 24-hour access to emergency care is maintained.

2. As part of the quarterly report, the State must provide HCFA with a listing of all changes in the provider network, including CHCs, Health Centers, public mental health clinics, and PPP clinics. In addition, the State must provide the number of patient visits per month by payor source provided in each clinic during the extension period.

3. As part of the quarterly report, the State must indicate the average waiting time for: routine primary care appointments, specialty care appointments, urgent care and emergency care. Further, the State must monitor the waiting times, analyze any increases or decreases, and take corrective measures, if appropriate. The corrective measures undertaken should be submitted as part of the quarterly report.

D. Quality Assurance/Quality Improvement

1. During the extension period, the State shall implement the Quality Assurance and Improvement (QA/I) plan for CHCs, Health Centers, public mental health clinics, and PPPs, as specified in the approved Project Management Plan.

2. As part of the approved Project Management Plan, the State established a process for bringing CHCs, Health Centers, mental health clinics, and PPPs that score below the established benchmarks for specific and overall quality assurance measures up to a level considered acceptable under the QA/I plan. The State will continue to follow this process during the extension period.

3. The quarterly reports shall summarize the nature of complaints received related to patient care, and the mechanism for resolution.

4. The approved Project Management Plan included the proposed minimum data set, appropriate for the age and health needs of the population to be served under the Project, and a work plan indicating how data collection would occur and be monitored. The work plan included: methodology for developing a baseline for comparison; indicators of quality used to determine if desired outcomes were achieved; data repository; methodology for validating data; and a mechanism for monitoring. In addition, it identified how the data would be used to pursue health care quality improvement and timely Project changes. The work plan shall remain in effect during the extension period.

E. Monitoring

1. The State will assure that provider contracts used under the extension of the Project meet any applicable requirements under State law. The State will monitor, on a regular or periodic basis, clinic providers participating in the extension of the Project to assure that those providers are adhering to the terms of their contracts.

2. * The State shall conduct two statistically valid sample surveys of all individuals receiving care under the provisions of the Project. The surveys during the extension period will measure satisfaction and include measures of waiting time for care, access to services, access to specialty services, physical environment, and staff/patient relations. Results of the first survey must be provided to HCFA within one quarter after all elements of the survey are completed, but no later than June 30, 2002. The results of the second survey shall be submitted by June 30, 2004. HCFA must approve the survey and the sampling methodology. The County must submit to the State for review and approval a draft report of each required survey at least ten (10) State working days prior to the HCFA submission deadline.

F. Management Information Systems

1. The Project Management Plan included a plan for the creation of a data repository and collection system for patient specific data (e.g., encounter data, service locations) from all County DHS patient care settings and contract providers. The State shall continue to collect this data.

Requirements for Federal Financial Participation/ Cost Control/Fiscal Administration

1. For the period from July 1, 2000 through June 30, 2005, in addition to all other amounts otherwise payable by HCFA to the State, HCFA will provide FFP at the applicable Federal matching rate for the following components of the extension of the Project in accordance with the provisions of Section 1903 of the Social Security Act, 42 C.F.R., part 430 through 456, (except as waived under the extension of this Project), 45 C.F.R., Part 95 Subpart F., and Part 11 of the State Medicaid Manual. Payment for all waiver components found in 1b and 1c of this Attachment, in combination, shall not exceed the annual and total budget limits described in Attachment D.

   a. **Administrative Costs.** Administrative cost categories associated with the administration of the extension of the Project include: development, performance and analysis of any surveys required by HCFA; operations of the Oversight Committee; development and maintenance of data collection systems and any other administrative costs associated with implementation of the extension of the Project. Such costs shall not be considered in determining compliance with the annual and total budget limits described in Attachment D and shall be only those allowable administrative costs that have not been previously claimed and paid as Medicaid program service costs. The State shall submit an annual administrative budget to HCFA, detailing both the State and County projected costs to administer the extension of the Project, 60 days prior to the beginning of the State fiscal year. For the first year of the extension, the administrative budget must be submitted within 60 days of approval of the Special Terms and Conditions.

   b. **Federally Reimbursable Ambulatory Service Costs.** Federally reimbursable ambulatory service costs incurred by the County in rendering services to indigent patients (as defined in V.A. of the Special Terms and Conditions) in CHCs, Health Centers (excluding clinics that provide predominately public health services), private clinics that provide health services to the indigent (including General Relief recipients) under contract with County DHS, public mental health clinics operated by County DMH, and private mental health clinics under contract with County DMH, to the extent that they are not otherwise reimbursed by third party payors, or private funds, such as private insurance or self-pay amounts. Such third party reimbursement shall not include those State and local funds received by, or provided by, the County as subsidies for services provided to indigent patients. The costs are to be incurred directly by the County and will be reported to State DHS and HCFA. These reports shall be submitted on a quarterly basis. Further, in addition to payments made by the County to its subcontractors, for the period from July 1, 2000 through June 30, 2005, certified public expenditures (CPE) will be recognized for the rental value of the County buildings and equipment provided to

privatized clinics as specified in the Public/Private Partnership Program Health Services Agreement. The County will provide assurance that services are being provided to indigent patients as specified in the Public/Private Partnership Program Health Services Agreement and that the cost of these services exceeds the CPE claimed for the building and equipment.

c. **Supplemental Project Pool.** Expenditures made as State disbursements in an amount to be known as the Supplemental Project Pool (SPP). The total amount potentially distributable through the SPP shall be $789 million over the five-year demonstration period, including FFP and non-Federal funds.

i. Annual and total Federal SPP funding shall not cause the State to exceed the annual and total budget limits described in Attachment D.

ii. SPP funding, together with other expenditures, including Federally reimbursable ambulatory service costs and Medi-Cal expenditures, shall not cause the State to exceed the upper payment limit requirement found at 42 C.F.R. § 447.321 for each year of the extension of the Project.

iii. The County shall be entitled to the total amount of the SPP through quarterly payments by certifying that at least 450,000 visits were rendered annually to Medi-Cal and indigent patients (as defined under the extension of the Project) in CHCs, Health Centers (excluding clinics that provide predominately public health services) and Mental Health clinics, either directly or pursuant to contracts with private entities, during each of the State fiscal years 2000-01 through 2004-2005.

2. * The State agrees to submit to HCFA on an annual basis, the entire certified report completed by an independent accounting firm that shall certify that the State has calculated Federally reimbursable ambulatory service costs for indigent patients consistent with these Special Terms and Conditions, Appendix B of the State/County Proposal, and as appropriate, generally accepted accounting principles. The report is due within 240 days after the end of each State fiscal year of the extension of the Project.

3. For the 1995-96 State fiscal year, disproportionate share hospitals (DSH) operated by the County of Los Angeles received the adjusted projected total payment adjustment amount calculated with respect to each such facility under subparagraph (C) of paragraph (6) of subdivision (y) of Section 14105.98 of the Welfare and Institutions Code, which was estimated to be $558 million. It has been determined that the Federal component of DSH payments received by the County for the 1995-96 State fiscal year was in excess of the OBRA 1993 limits. The State is obligated to repay these Federal funds. The OBRA 1993 hospital-specific DSH limit has been determined in accordance with Section

1923(g) of the Social Security Act and such other implementing regulations, guidance or policy statements. The amount of the State obligation to repay shall be submitted to HCFA Regional Office with supporting documentation no later than November 1, 2000. Upon HCFA acceptance of the amount of the obligation, repayment of the Federal funds shall be due on an installment basis over the maximum repayment period allowed under 42 C.F.R. Section 430.48. For purposes of applying 42 C.F.R. Section 430.48, and determining the repayment schedule thereunder for the State repayment obligation, the amount of the non-Federal share of the annual Medi-Cal revenues received by the County shall serve as the "annual State share for the Medicaid program" and "annual State share of Medicaid expenditures" as used in 42 C.F.R. Section 430.48.

4. HCFA approved the Accounting and Procedures Agreement, a detailed and specific description of the documentation and accounting process for items 1 through 3. FFP must be accounted for in a manner that HCFA agrees does not constitute a breach of the OBRA 1993 statute. In addition, for each Project year of the Project extension, the County will certify that amounts expended at the local level as the non-Federal portion of the federally reimbursable ambulatory service costs will consist only of funds eligible for FFP in accordance with 42 C.F.R. 433.51.

5. * The State must amend the Operational Protocol to include the following:

   a. Revised budget limit information consistent with the agreement specified in these Special Terms and Conditions.

   b. A detailed description of the sources and uses of State, County, private, and Federal funds that ensures that sources are derived in accordance with applicable Federal laws and regulations, specifically Section 1903(w) of the Social Security Act and 42 C.F.R. § 433.50 et seq.

   c. Detailed information regarding the SPP to include a specific description of the source of pool funds, how payment amounts will be determined, and what accounting process will exist.

   See Attachment B for rules on amending the Operational Protocol.

6. The State will report net expenditures in the same manner as under the current Medi-Cal program. The State shall provide quarterly expenditure reports using the form HCFA-64 to separately report expenditures for those services provided under the regular Medi-Cal program and those provided under section 1115 authority (extension of the Project). Only those expenditures authorized pursuant to this Attachment A shall be separately identified as section 1115 authority (extension of the Project) expenditures. The latter category is to include all expenditures identified as being subject to the annual and total budget limits specified in Attachment D. For the purpose of reporting expenditures provided under 1115 authority (extension of the Project), SPP expenditures are to be reported on a date of payment basis. All other applicable expenditures are to be

reported on a date of service basis. HCFA will provide FFP only for allowable expenditures that do not exceed the annual and total budget limits specified in Attachment D.

7. * The State will report expenditures through the Medicaid Budget Expenditure System (MBES), following routine HCFA-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. In this regard, the Project expenditures under the extension will be differentiated from other Medicaid expenditures by identifying on forms HCFA-64.9 and/or 64.9p the demonstration project number assigned by HCFA (including the project number extension which indicates the demonstration year the services were rendered). The procedure referred to under this paragraph must be approved by HCFA as part of the Operational Protocol.

8. All claims for FFP under the extension of the Project (including any cost settlements) must be submitted to HCFA within two years after the end of the calendar quarter in which the State or County made the expenditures. During the period following the conclusion or termination of the extension of the Project, the State must continue to separately identify the Project expenditures under the extension using the procedures addressed in paragraphs 6 and 7 above.

9. The standard Federal Medicaid funding process will be used during the extension of the Project. The State must estimate matchable California Medicaid and Project expenditures under the extension on the quarterly form HCFA-37. The State must provide supplemental schedules that clearly distinguish between Project expenditure estimates under the extension (by major component) and non-Project Medicaid expenditure estimates. HCFA will make Federal funds available each quarter based upon the State's estimates, as approved by HCFA. Within 30 days after the end of each quarter, the State must submit the form HCFA 64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. HCFA will reconcile expenditures reported on the Form HCFA-64 with Federal funding previously made available to the State for that quarter, and include the reconciling adjustment in a separate grant award to the State.

10. The State shall provide to HCFA, upon request, copies of all audits conducted on the extension of this Project.

Attachment B

General Administrative Requirements

1. * The State shall amend the Operational Protocol to include all requirements of these Special Terms and Conditions and Attachments governing the extension of the Project. Amendments to the Operational Protocol necessitated by these Special Terms and Conditions must be submitted to HCFA no later than March 30, 2001. HCFA will respond within 45 days of receipt of the amendments to the Operational Protocol, regarding any issues or areas it believes require clarification. HCFA and the State will make every reasonable effort to ensure that the amendments to the Operational Protocol are approved within 60 days from the date of its original submission.

2. * The State shall request modifications to the extension of the Project by submitting revisions to the Operational Protocol for HCFA approval. During the course of the extension, changes to the Operational Protocol that are the result of major changes in policy or operating procedures shall be submitted no later than 90 days prior to the date of implementation of the change(s) for approval by HCFA.

3. * The State shall amend the Interagency Agreement, which was formally incorporated into the Operational Protocol, to reflect all requirements of these Special Terms and Conditions and Attachments governing the extension of the Project. Amendments to the Interagency Agreement necessitated by these Special Terms and Conditions must be submitted to HCFA no later than February 28, 2001. HCFA will respond within 45 days of receipt of the amendments to the Interagency Agreement, regarding any issues or areas it believes require clarification. HCFA and the State will make every reasonable effort to ensure that the amendments to the Interagency Agreement are approved within 60 days from the date of its original submission.

4. * During the course of the extension, any changes to the Interagency Agreement shall be submitted no later than 30 days prior to the date of implementation of the change(s) for approval by HCFA.

5. * The Accounting and Procedures Agreement shall be amended to reflect all requirements of these Special Terms and Conditions and Attachments governing the extension of the Project. Amendments to the Accounting and Procedures Agreement necessitated by these Special Terms and Conditions must be submitted to the HCFA no later than March 30, 2001. HCFA will respond within 45 days of receipt of the amendments to the Accounting and Procedures Agreement, regarding any issues or areas it believes require clarification. HCFA and the State will make every reasonable effort to ensure that the amendments to the Accounting and Procedures Agreement are approved within 60 days from the date of its original submission.

6. * During the course of the extension, any changes to the Accounting and Procedures Agreement shall be submitted no later than 30 days prior to the date of implementation of the change(s) for approval by HCFA.

7. * Substantive changes to the Project extension's design will require submission of a formal amendment to the extension of the Project and advance HCFA approval.

8. All contracts and subcontracts for services related to the extension of the Project must provide that (1) the County may evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed; and (2) the County, State DHS and the U.S. Department of Health and Human Services may inspect and audit any financial records of such contractor/subcontractors. This includes all contracts (as referenced in Section V.B. of the State/County Proposal) with private organizations that will operate a Health Center or Clinic under the extension of the Project.

9. HCFA will contract with an independent contractor to evaluate the extension of the Project. The State agrees to cooperate with the evaluator by responding in a timely manner to requests for interviews, providing access to records, and sharing data, including claims, encounter, and eligibility files. Neither the County nor the State may charge the evaluator for access to records or other information. The State and the County have the right to review reports and the right to comment on reports prepared by the evaluator.

Attachment C

General Reporting Requirements

1. The State will submit quarterly progress reports, which are due 60 days after the end of the quarter. The first two quarterly reports will be due within 60 days following the approval of these Special Terms and Conditions. The reports should include a brief narrative of events occurring during the quarter that will affect access to health care, restructuring, quality of care (including statistics on grievances), the County's financial viability or other key operational areas. The reports should include a separate discussion of County efforts related to the collection and verification of encounter data. The reports should also include proposals for addressing any significant problem areas. In addition, monthly conference calls with the HCFA project officer and HCFA Regional Office representatives will be held to discuss the progress when appropriate.

2. * The State will submit a draft annual report, documenting accomplishments, status of the extension of the Project, quantitative and case study findings, and policy and administrative difficulties. In addition, the State should incorporate into the annual report a description of programmatic changes to the Los Angeles County health care system that will be necessary, as a result of phasing out demonstration funding. This description shall be updated annually to reflect any relevant changes in plans and/or priorities. The annual report shall be submitted to HCFA no later than 90 days after the end of each State fiscal year. Within 30 days of receipt of comments from HCFA, a final annual report will be submitted.

3. At the end of the extension period, a draft final report should be submitted to HCFA for comments. HCFA's comments should be taken into consideration by the State for incorporation into the final report. The State should use the HCFA, OSP's Author's Guidelines: Grants and Contracts Final Reports (copy attached) in the preparation of the final report. The final report is due no later than six months after the termination of the extension period.

4. The County will submit to the State for its review and approval a draft version of each of the reports described above at least ten (10) State working days prior to the submission deadline to HCFA.

Attachment D

Monitoring Budget Limits

This attachment describes the budget limits that will be applied under the phase-out extension of the Project. The State will be subject to a limit on the amount of Federal funding that it may receive under this extension of the demonstration for expenditures described in paragraph 1 of Attachment A of these Special Terms and Conditions (except expenditures for otherwise allowable administrative expenditures)**,** hereinafter referred to as demonstration FFP. Funding will be provided in decreasing percentages over the term of the extension, as detailed below. The budget limit on this five-year extension is $900 million in demonstration FFP on expenditures described in paragraph 1 of Attachment A (excluding funding for allowable administrative costs). This amount was calculated by applying the yearly phase-out percentages listed below to a base figure of $246,600,000. The resulting annual limits appear in the table below. The base figure represents the estimated amount of Federal reimbursement for costs-not-otherwise-matchable provided to the State for the final year of the original demonstration (SFY 1999-2000), which complied with budget neutrality requirements as defined in the original demonstration. Demonstration FFP can only be claimed for County expenditures up to the annual limits imposed under the phase-out schedule appearing in the table below, not to exceed $900 million over the five-year extension period. The goal of this schedule is to reduce County dependence on demonstration FFP provided in Attachment A from an estimated $246 million in Year 5 of the original demonstration through a complete phase-out of expenditures in Attachment A by the first post-demonstration-extension year (SFY 2005-06).

State Fiscal Year	Percent Limit On Demonstration FFP	Dollar Limit on Demonstration FFP
2000-01	100%	$246,600,000
2001-02	100%	$246,600,000
2002-03	75%	$185,000,000
2003-04	55%	$135,500,000
2004-05	35%	$86,300,000
2005-06 post-extension	0%	$0
Total		**$900,000,000**

Any future amendment proposals, if found to be acceptable by HCFA on programmatic grounds, will be financed under the $900 million five-year cap and each applicable annual cap on demonstration FFP as specified in the budget limit table above.

If at the end of each demonstration year HCFA determines that the annual cap on demonstration FFP has been exceeded or at the end of the phase-out HCFA determines that the $900 million five-year cap has been exceeded, the State will return the excess Federal funds to HCFA.